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November 24, 2003

MEMORANDUM

TO: Area Program Directors

FROM: Richard J. Visingardi, Ph.D.

RE: CAP-MR/DD Waiver: Aggregate Funding Management Response to NC Council of Community Programs

I received a letter from Dr. Jack St. Clair with specific questions about the management of the CAP-MR/DD waiver funds in aggregate. The questions in the letter that asked about the formula for determining the virtual allocation were answered within the text of the Budget Team's allocation letter. Questions about the process for accessing Trust Fund monies for consumers being de-institutionalized from state operated mental retardation centers will be addressed in specific detail in a memo from the State Operated Services Section later this month.

The following is a list of the remaining questions and responses:

1. *What are the desired outcomes, how will they be tracked and evaluated? It is not clear what is expected other than, "as many people as can be served, should be served."*

There are several desired outcomes that may be achieved by the move to managing the waiver budget through aggregate funding. The first of these is to not overspend the state's waiver budget. For the past three years, in spite of efforts to contain a runaway inflation, the budget has been overspent by between 4 and 11 percent. Before attempting to hold area/county programs accountable for managing a budget, it is first necessary to inform them of exactly what funds are attributed to their individual portions of the statewide budget. Prior to the "virtual allocations" of this year, area programs never had a bottom-line knowledge of the amount, which would represent their portion of the statewide budget. It is important to remember that the waiver budget, like all Medicaid funding, has a local match as well as a state match with which to draw down federal dollars. Aggregate funding management is intended to assist the area/county programs to assess and appreciate the local ownership of these funds.

A second desired outcome is to serve as many persons as possible, effectively and efficiently. It is not the desire or the intent of the Division to "micro-manage" this process. If the expectation of the area program is to serve 100 consumers and only 20 are brought into service, or 150 are brought into service, the Division will need to work with the area program to understand the circumstances that created the discrepancy between expectation and experience. The projected numbers of persons to be served, as well as the virtual budgets, includes the expectation that consumers will be brought into the community from the state operated mental retardation centers. If an area program serves the expected number of persons, but has not moved any consumers from the mental retardation centers, the Division will need to work with that area program to understand what system barriers are preventing de-institutionalization.

One of the most important elements to remember is that the important outcomes are those gained by consumers. Too many of the discussions about aggregate funding end up pitting budget issues against consumer need. The rules of the waiver, both federal and state, have not changed. An area program can not refuse to meet the medical needs of a consumer who is receiving waiver services. The important discussions are still the ones that happen with consumers in their homes rather than the ones happening between the area program's finance officer and a case manager. All parties to the waiver should be aware of the limited funding that is available to meet an unlimited need. This requires all parties, area program staff, families and providers, to adhere to a commitment of stewardship of public funds. Service planning should include both discussions about the difference between need and want, and what natural supports or other community resources may be able to assist a client.

The outcomes of "remaining within budget" and "serving new persons" is tracked monthly through the fiscal analysis report generated by the Division Budget Team. This report includes a raw count of the number of CAP recipients receiving services generated by a total of Medicaid ID numbers billing for services. These reports are to provide a road map for the area program to gage their spending progress, to allow the Division to assist if area programs appear to be over or under utilizing their funding, and to allow both the area/county programs and the Division to learn more about managing these funds in aggregate.

2. How will the virtual budgets be evaluated, adjusted and what is the timetable for doing so?

The 2003-2004 fiscal year is the first full year of aggregate funding management. We do not anticipate making any adjustments to individual virtual budgets this year. We want to see each area program manage the funds within their allocation. We recognize that some have historically demonstrated a higher cost per consumer than others have and we anticipate some discrepancies between the numbers projected to be served, and the actual experience for those area/county programs with higher individual averages. Over time, both the area programs and the Division need to understand what drives the variations in average cost per consumer, regionally, across the state. Part of the incentive of the aggregate funding is to allow the area programs to use the funding that results in their management efficiencies for their own community. It is important to remember that new consumers entering waiver service this year will not expend the total of their annualized services. The area/county programs will need to be able to capture sufficient data to project what the subsequent year's annualized expense might be in order to appreciate the differences between the initial year's budget margins and those of subsequent years.

3. *What will be the reporting requirements and frequency of the reporting?*

The initial virtual allocation memo stipulates that area programs submit the Medicaid ID number for new consumers, as they enter into services to Kent Woodson of the Budget Team. The only other reporting mechanism currently required for aggregate funding is the paid claims data, which the Division draws down from the EDS MMIS. The paid claims data is reconfigured into the fiscal analysis report returned to the area programs by the Division Budget Team each month. There will be an additional expectation of reporting information related specifically to consumers that are de-institutionalized from the state operated mental retardation centers. The State Operated Services Section will provide a memorandum outlining those requirements by the end of October.

4. *We have asked to work with the Division and other stakeholders to identify a way a resource pool could be developed particularly for Olmstead, high need recipients.*

The waiver continues to stipulate a maximum amount available per person of $86,058 per year. Therefore a resource pool of waiver funding is not an option to support high need consumers on an ongoing basis. The Division has increased the flexibility for the use of MRMI funds to provide additional support for those consumers who qualify for waiver and are dually diagnosed. In addition, Trust Fund monies are available to support one-time costs of de-institutionalizing a consumer from a state operated mental retardation center. The State Operated Services Section will have additional information regarding the process for accessing Trust Fund monies distributed to area programs by the end of October.

The Division will be keeping a minimal resource fund at the Division level to assist on a one-time basis for unanticipated expenses (adaptive equipment, etc.). This resource fund will be small and not sufficient to cover gross over-expenditures by any or all area programs. We will be happy to work with the Council to establish a protocol for how the resource funds may be distributed.

5. *Determine and disseminate how expansion dollars will be allocated and earned.*

Answered in the recent allocation memo.

6. *Develop and disseminate how area programs over budget will be handled.*

It is important to remember that the concept of aggregate funding applies not only to area programs, but also to the state as a whole. If one area program is a little over budget while another is a little under budget, then the state, as a whole will be operating within budget. However, if a majority of area programs operate over budget, then the state as a whole will be over budget and jeopardize the ongoing stability of the waiver. The issue of "handling" area/county programs over budget will be a developmental part of the emerging LME process and will not be definitively addressed during this first learning year of aggregate funding.

7. *Work conjointly with the Council to discuss differences in roles and responsibilities between the area program/county program case manager/care coordinator and the Division's technical assistance and support, particularly for placing Olmstead clients or in working through issues with institutions.*

The State Operated Services Section is developing guidelines for working through issues of placement of Olmstead consumers. In addition, the Division is considering the most appropriate mechanisms for providing consistent support and technical assistance to area programs for challenging and complex clinical cases. It is also expected that the area programs will come to the table in these efforts for mutual and real problem solving as opposed to a "You find a place for this consumer," approach by either party. The history of working with complex cases has too often resulted in a placement in a state institution. The community network of area/county program, providers, consumers and families will ultimately be the best resource to resolve the issues within the parameters of the available resources. The guidelines will be available by the end of October.

8. *Distribute protocols for accessing the MH Trust Fund and MR/MI dollars.*

Area Programs have already received MR/MI transition memos dated February 11, 2003, "MRMI Transition"; April 4, 2003, "ADMRI Funding through IPRS"; and August 28, "ADMIR Target Population Clarification", indicating how to access this funding. Essentially, if the consumer meets the IPRS target population criteria, they can receive the funding. The decision to use these monies, within the current allocation is already in the hands of each area/county program. Information about the process to access Trust Fund monies will be included in the communication from the State Operated Services Section.

RJV/lh

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